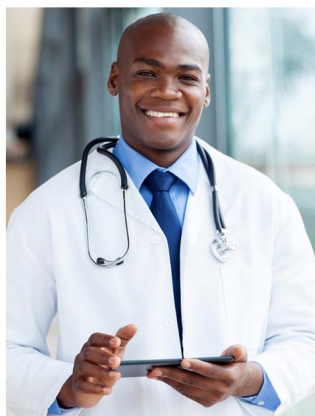




Idaho Telehealth Plan



BROADBANDUSA
CONNECTING AMERICA'S COMMUNITIES



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Idaho Telehealth Task Force

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INTRODUCTION

Since 2013, the Idaho Telehealth Task Force has been working to establish and support a coordinated statewide consortium of stakeholders who promote the appropriate use of telehealth services for meeting the health care needs of Idahoans. Through its work with LinkIDAHO to provide training and technical assistance for broadband planning and implementation under the State Broadband Initiative (SBI),¹ ICF International (hereafter referred to as ICF) joined with the Idaho Telehealth Task Force to help guide the Task Force in moving telehealth forward in Idaho. ICF, in close collaboration with the Task Force, conducted several research activities to identify the next steps for promoting a coordinated, collaborative, and strategic approach to supporting the expanded use of telehealth to provide health care in Idaho.

Overview of the Idaho Telehealth Task Force

In March 2013, Idaho State Representative John Rusche convened a group of stakeholders to begin to understand the current status and needs for telehealth in Idaho, as well as the statewide assets that could encourage the use of telehealth, and the barriers to its adoption in the State. The Task Force has evolved into a strong collaboration between more than 80 key partners, including hospital administrators, health care providers, professional associations and advocacy organizations, educational institutions, Federal and State Government agencies, information technology providers, insurers, and private industry representing all regions of Idaho. The Idaho Telehealth Task Force supports:

- **parity in reimbursement** between telehealth and traditional care for all areas of medicine for which there is evidence-based data demonstrating the effectiveness of telehealth;
- **policy changes**, which allow regional and/or national licensure of health care providers to facilitate delivery of services across state lines via telehealth;
- **sharing of outcome data** across organizations to demonstrate the degree to which telehealth increases access to health care to underserved populations, improves patient outcomes and reduces costs for care delivery.²

To date, the Idaho Telehealth Task Force has achieved a variety of major steps toward its goal of promoting the expanded use of telehealth throughout the State. These include a statewide survey of the use of telehealth in critical access hospitals, a telehealth reception in association with the Idaho Broadband Summit,³ and the release of a new website with specific areas for disseminating telehealth information. In addition, in August 2014, the Task Force delivered the Idaho Telehealth: Gateway to the Future conference.⁴ In March 2014, the Idaho State Legislature passed House Concurrent Resolution (HCR) 46 to direct the Idaho Department of Health and Welfare to create the Idaho Telehealth Council to coordinate and develop a comprehensive set of standards, policies,

¹ SBI was a grant to all 50 states and some territories under the American Recovery and Reinvestment Act (ARRA) to conduct broadband planning and mapping for each state. The SBI grant for Idaho resides with the Idaho Rural Partnership, under the direction of State Broadband Coordinator Mike Field.

² Idaho Telehealth Task Force: A Statewide Collaboration Facilitated by AHEC (Area Health Education Center). http://www.idahoahhec.org/index.php?option=com_content&view=article&id=124&Itemid=302

³ Update on the Idaho Telehealth Task Force. Presentation to the LinkIDAHO Broadband Advisory Team (LBAT), March 11, 2014.

⁴ <http://idahoahhec.org/idaho-telehealth-gateway-to-the-future/>

rules, and procedures for the use of telehealth throughout the State.⁵ This legislation directs members of the Telehealth Task Force Executive Committee to serve with others specified by HCR 46 on the Council. Activities related to legislation and reimbursement, and licensing and credentialing will be transitioned to the Council, while the Task Force will serve as a membership-supported, grassroots organization focused on education and advocacy for Telehealth.

Purpose of the Idaho Telehealth Plan

ICF International worked closely with the Task Force to design and conduct several research activities designed to improve the Task Force's understanding of the needs for, and uses of, telehealth as well as to identify barriers and facilitators to its use. ICF synthesized the findings from those research activities to identify potential next steps the Task Force can take to expand telehealth services throughout the state and promote effective and safe medical care. A summary of the key findings and accompanying recommendations are presented in this plan that is designed to

- improve understanding of the current use of telehealth services at the regional and state levels;
- identify barriers and facilitators to current use of telehealth;
- serve as a compendium of recommended strategies for expanding the use of telehealth;
- foster conversation and consensus regarding what should be the high priority action steps;
- guide the task force in choosing strategies that are the most feasible and impactful.



The following sections of the plan will present

- a discussion of the methods, including the data collection activities;
- a synthesized summary of key findings from the data collection activities;
- recommendations for action steps and potential strategies;
- a discussion of next steps.

METHODS

ICF's approach for the development of this Telehealth Strategic Plan for Idaho was two-pronged and included: 1) review of previous data collection and assessment activities and 2) conduct of additional data collection activities to help fill the gaps.

Previous data collection activities reviewed by the ICF team include:

- **Telehealth Questionnaire: Idaho Critical Access Hospitals.** In July 2013, the Idaho Telehealth Task Force administered a questionnaire to all 27 critical access hospitals in Idaho; 14 hospitals responded to the survey. The questionnaire aimed to conduct an inventory of the hospitals' telemedicine services, resources, and needs to inform the

⁵ http://www.idahoahc.org/index.php?option=com_content&view=article&id=119&Itemid=312

expansion of telehealth services in Idaho. See Appendix B for a table summarizing the study results.

- **Idaho Statewide Healthcare Innovation Plan (SHIP).** In December 2013, the Idaho Department of Health and Welfare developed a plan to inform a redesign of the State primary care system to a patient-centered medical home (PCMH) model of patient-centered, team-based, coordinated care. The plan has been endorsed by public and private payers; health care providers, consumers; and health care services throughout the State.
- **Idaho Time Sensitive Emergency Program.** During the 2013 Legislature, the Idaho Health Quality Planning Commission requested that the Legislature adopt HCR 10. This resolution directed the Idaho Department of Health and Welfare to convene a workgroup to define the elements of funding mechanisms for and an implementation plan for a comprehensive system of care for time sensitive emergencies in the State. The resolution passed and the workgroup was formed in May 2013. This workgroup drafted legislative language for the 2014 Legislative Session that lays the groundwork for a comprehensive, coordinated and evidence-based emergency system that will support trauma, stroke, and heart attack patients in Idaho.

After reviewing the work conducted and accomplished across the three efforts noted above, staff from ICF, in collaboration with the Idaho Telehealth Task Force, conducted five additional information-gathering tasks:

- **Unstructured Discussions.** A series of short, unstructured telephone discussions were conducted with approximately 10 individuals representing various subcommittees of the Idaho Telehealth Task Force as well as their partners and stakeholders in telehealth. Each of these conversations lasted approximately 30 minutes. The purpose of these discussions was to gather additional information about the topic areas each of their subcommittees focused on (i.e., licensure and credentialing, reimbursement, education) and to gather suggestions about areas to explore during the regional stakeholder interviews (described below).
- **Population Health Assessment.** This task included a review and synthesis of publically available secondary data to provide a comprehensive picture of Idaho's health status. The assessment includes discussions of regional demographics, key health factors and outcomes, and health care access and use.
- **Background Review of Policies, Enablers, and Barriers to Telehealth for Idaho.** This task involved a review of information gathered on several issues, including policy and legislative decisions that impact the use of telehealth services in Idaho. The resulting report includes a brief overview of key Federal and State policies, as well as discussions of potential enablers and barriers these policies may present to the use of telehealth in Idaho.
- **Regional Stakeholder Interviews.** Thirteen, 1-hour telephone interviews were conducted with individuals identified by Task Force members as knowledgeable about the telehealth services in their respective regions. Stakeholders from all regions, with the exception of Region 3, participated in the interviews.
- **Additional Key Informant Interviews.** To gather additional information from the perspectives of payers/insurers and state regulatory boards, two additional 1-hour telephone interviews were conducted with key informants identified using purposive sampling. These interviews provided additional insight on issues related to reimbursement, licensing and credentialing, and standards of care for telehealth service delivery.

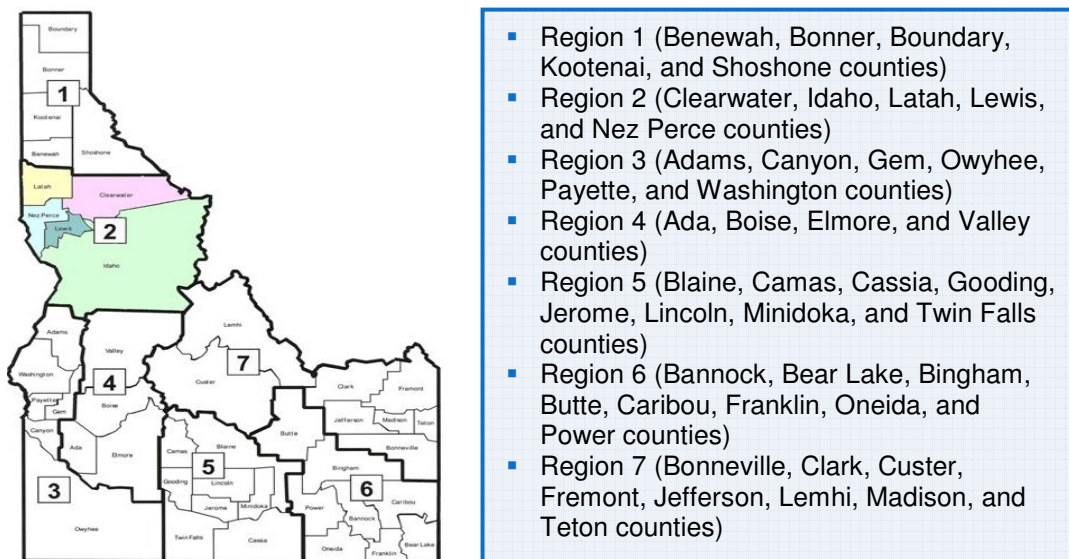
SUMMARY OF KEY FINDINGS

This section provides a summary of the key findings from the unstructured discussions, population health assessment, background document review, regional stakeholder, and additional key informant interviews. It is organized as follows: 1) a brief description of the State of Idaho; 2) a review of the key health concerns for the residents of Idaho; 3) a discussion of residents' access to health care services; 4) a review of several policy-related issues (licensure, reimbursement, privacy and security, and broadband infrastructure) that impact the delivery of telehealth services in Idaho; 5) a summary of the current telehealth services provided; and 6) facilitators and challenges to the use of telehealth services.

The State of Idaho: A Brief Description

Idaho is a mountainous State in the Pacific Northwest region of the United States. The total population of Idaho is 1,612,136. From 2010–2013, the State's population increased 2.6%. The State's Hispanic population has grown continuously at a high rate, with an increase of 82.1% from 2000–2010 and an overall population of 185,160 in 2012.⁶ Idaho is an important agricultural State, producing nearly one-third of the potatoes grown in the United States.⁷ Wheat, sugar beets, and alfalfa hay are also major crops. Mining and lumber industries also have been important to the State's economy. Thirty-five of Idaho's counties are rural,⁸ accounting for approximately 88% of the State's land area.⁹ Idaho is the seventh most rural State in the country, and half of Idaho's counties have fewer than 10 people per square mile. Exhibit 1 is a detailed map of Idaho's counties and regions.

EXHIBIT 1. STATE OF IDAHO COUNTIES, REGIONS, AND POPULATIONS



⁶ <http://indicatorsidaho.org/DrawRegion.aspx?RegionID=16000>

⁷ Beedasy, Jaishree. (2010). Rural Designations and Geographic Access to Tertiary Healthcare in Idaho. *The Online Journal of Rural Research and Policy*, 5.2 1–21.

⁸ Rural counties are defined as those with no cities of more than 20,000 residents.

⁹ <http://irp.idaho.gov/>

Idaho's median household income falls below the national median. While the average median household income in the U.S. between 2008 and 2012 was \$53,046, Idaho's was \$47,015.¹⁰ Education levels in Idaho are comparable to those across the United States. Most notably, more Idahoans complete high school and obtain associate degrees when compared with the overall U.S. population.^{11,12} In 2012, the rate of poverty in Idaho was comparable to that of the overall United States (16% vs. 15.9%, respectively). However, this rate illustrated significant growth as the poverty rate increased from 11.8% in 1999. When all states are ranked from the highest to lowest poverty rates, Idaho ranks 22nd and has a higher poverty rate than more than half of the states in the country.¹³

Idaho is home to six federally recognized tribes: Coeur d'Alene Tribe, Kootenai Tribe of Idaho, Nez Perce Tribe, Shoshone-Bannock Tribes, the Northwestern Band of the Shoshone Nation, and the Shoshone-Paiute Tribe.¹⁴

The State's low population density, expansive landscape, and harsh terrain create problems of distance and isolation for residents, particularly when it comes to obtaining health care services. Geographical access to health services presents barriers of cost, time, and inconvenience. Rural, low-income, and minority communities often have poorer health outcomes as a result of unbalanced distribution of health care providers and services.¹⁵

Key Health Concerns

Idahoans face a range of health concerns related to weight and obesity, smoking, mental illness, vaccinations, cholesterol, and dental care. Key statistics¹⁶ include the following:

- In 2010, 62.3% of adults were overweight; 27.0% were obese; in 2011, 13.4% of children were overweight; 9.2% were obese.¹⁷
- Idaho ranked 15th in the country in prevalence of adult smokers (17.2% were smokers).
- In 2008–2009, 22.5% of Idahoans age 18 or older had a mental illness.¹⁸ Of 44 counties, 28 have no psychiatrists at all and 21 have no psychologists. One quarter of the population of Idaho has no access to these mental health providers within their own county, and every county in the State is classified as an underserved area for behavioral health.¹⁹
- In 2012, Idaho ranked 43rd for the percent of children ages 35 months to 19 who received all recommended vaccines.

¹⁰ <http://quickfacts.census.gov/qfd/states/16000.html>

¹¹ Data present average percentages of educational attainment for Idahoans age 25 or older from 2008–2012

¹² <http://indicatorsidaho.org/DrawRegion.aspx?RegionID=16000&IndicatorID=100043>

¹³ <http://indicatorsidaho.org/DrawRegion.aspx?RegionID=16000>

¹⁴ Federal Register, Vol. 77, No.155. August 10, 2012

¹⁵ Telehealth Evaluation: Population Health Assessment. ICF International, June 2014

¹⁶ Idaho Behavioral Risk Factors: Results from the 2011 Behavioral Risk Factor Surveillance System. Idaho Department of Health and Welfare, Division of Health, Bureau of Vital Records and Health Statistics, 2014.

¹⁷ Idaho (2013). (SHIP).

¹⁸ Mental Health, United States, 2010 Report produced by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, <http://www.samhsa.gov/data/2k12/MHUS2010/MHUS-2010.pdf>

¹⁹ Update on the Idaho Telehealth Task Force. Presentation to the LinkIDAHO Broadband Advisory Team (LBAT), March 11, 2014.

- In 2011, 32. % of Idaho adults had a cholesterol check in the past 5 years.
- In 2011, 34.2% of Idaho adults had not visited a dentist in the past 12 months.

Access to Health Care Services

The extent to which Idaho residents have access to health care services is key to identifying gaps that can potentially be filled by expanding use of telehealth services throughout the State. The Idaho health care delivery system is challenged by a shortage of primary care providers and large rural areas that limit residents' access to critical health care services. In 2011, there were 1.6 physicians per 1,000 residents in Idaho, compared with 2.5 physicians per 1,000 in the United States.²⁰ Across individual counties, the availability of physicians ranges from zero per 1,000 in Camas County to 2.9 per 1,000 population.²¹

Access to health care is particularly challenging for tribal communities. In the SHIP report (SHIP; 2013), tribal representatives noted that tribal communities experience serious difficulties accessing adequate health services, particularly for behavioral health. Primary care providers in tribal health centers or the Indian Health Service (HIS) experience difficulties coordinating care with providers outside of the tribal community.

While Idaho experiences a significant shortage of dentists and primary care providers, the shortage of mental health providers is even more substantial. Specifically, there is

- one dentist for every **1,586 Idahoans**;
- one primary care physician for every **1,969 Idahoans**;
- one mental health professional for every **19,583 Idahoans**.²¹

Ninety-six percent of Idaho is a federally designated health professional shortage area (HPSA) in primary care.²² HPSAs are defined as geographic areas, populations, or facilities identified as having too few primary medical, dental, or mental health providers to meet the needs of a given community. Idaho currently contains 336 designated HPSAs.²² Similarly, 100% of Idaho is federally designated as a shortage area in mental health care, indicating a lack of psychiatrists, psychologists, or both in several counties. Specifically, 23% of the overall population lives in a county without a psychiatrist, 14% live in a county without a psychologist, and 13% live in a county without a psychiatrist or psychologist.²³ Regional stakeholders also identified mental health as a service that patients often had difficulty accessing. Respondents also mentioned all specialty and sub-specialty care, with an emphasis on cardiac care, dermatology, stroke, neurology and oncology.

Current State of Telehealth in Idaho

The expansion of telehealth services in Idaho is influenced by several policy related factors including licensure, reimbursement, and procedures regarding privacy and security. This section provides a brief description of the State of Idaho's approach to each and how it aligns with national guidelines and/ or other States' approaches.

²⁰ <http://indicatorsidaho.org/DrawRegion.aspx?RegionID=16000&IndicatorID=29>

²¹ <http://indicatorsidaho.org/DrawRegion.aspx?Action=DrawRankings&RegionID=16000&IndicatorID=29>

²² <http://datawarehouse.hrsa.gov/topics/hrsainyour/factsheetstate.aspx?geocd=16>

²³ <http://muafind.hrsa.gov/>

Licensure

Defining what constitutes telehealth is critical to determining whether a health care provider is licensed to provide telehealth services. The Federation of State Medical Boards (FSMB) recently revised its definition of telemedicine and its position on medical licensure for telehealth service delivery.²⁴ According to the new policy guidelines released on April 26, 2014, telemedicine is care that “typically involves the application of secure videoconferencing ... to provide or support health care delivery by replicating the interaction of a traditional encounter in person between provider and a patient.” It is not, according to the federation, “an audio-only, telephone conversation, e-mail/instant messaging conversation or fax.”²⁵ FSMB’s policy statement also recommends that physicians

- obtain a license in the state where the patient is located;
- verify the identity and location of the patient they are treating;
- disclose professional credentials;
- acquire consent form from the patient for the care they are delivering;
- not write patient prescriptions that are based only on an online questionnaire.²⁶

The revised guidelines further enable telehealth, because they endorse the initiation of a patient-physician relationship, via telehealth, regardless of whether an initial in-person encounter between patient and physician has taken place, and provided the standard of care is met.²⁷

The State of Idaho requires a full, unrestricted medical license for physicians to provide telehealth services in the State. For example, an out-of-state physician who regularly reads radiologic or imaging studies that were (1) conducted in Idaho, (2) by Idaho physicians, and (3) on patients in Idaho is required to hold a medical license in Idaho. This approach is in accordance with FSMB’s recommendation and is common in many states. However, both the cost of obtaining the second license and the amount of time the process takes can be challenging.

To address this issue, Idaho is one of the first of several states (with Iowa, Michigan, Nevada, New Mexico, North Carolina, Oregon, and Rhode Island) to offer expedited licensure process. The process allows physicians who are in good standing in their own state, have no significant malpractice or disciplinary history, and who submit to a criminal background check, to complete the licensing process in Idaho in 2 to 3 weeks, instead of the normal 45 days.²⁸ This expedited process has been in place for approximately 5 years. However, findings from the regional stakeholder interviews indicate that awareness and use of this process has been limited. The few respondents who had heard of the process did not know much about it and estimated that completion of the process takes from 30 days to 8 months.

In Idaho, the licensing laws for other health care professionals differ. For example, Idaho is part of the Nurse Licensure Compact (NLC), along with Delaware, Kentucky, Maine, Maryland, New Hampshire, North Carolina, South Carolina, Virginia, Tennessee, Mississippi, Arkansas,

²⁴ <http://www.luc.edu/media/lucedu/law/centers/healthlaw/pdfs/advancedirective/pdfs/issue1/clifton.pdf>

²⁵ http://www.fsmb.org/pdf/FSMB_Telemedicine_Policy.pdf

²⁶ http://www.fsmb.org/pdf/FSMB_Telemedicine_Policy.pdf

²⁷ <http://vsee.com/blog/category/vc-opinion/>

²⁸ <http://www.hrsa.gov/ruralhealth/about/telehealth/licenserpt10.pdf>

Missouri, Iowa, Wisconsin, North Dakota, South Dakota, Nebraska, Colorado, New Mexico, Texas, Arizona, and Utah. Nurses must obtain only one multistate license in their primary state of residence to provide services via telehealth in other participating states.

An Idaho statute states that providers of telepsychology licensed in another state may practice in Idaho for up to 30 days within a calendar year if they hold an interjurisdictional practice certificate (IPC).²⁹ This statute also authorizes the psychology licensing board to develop standards and requirements addressing the use of communication technology in the practice of psychology, including supervision.

The Idaho State Legislature passed HCR 46 to set State standards for the provision of telemedicine, which will help ensure that health care professionals can be confident that the care they provide remotely complies with State licensing regulations.

Reimbursement for Non-Mental Health Services

Nationally, there are three primary sources of reimbursement/payment for telemedicine services—Medicare, Medicaid, and private payers. Only 21 states require private health insurance plans to cover telemedicine. States also vary on parity laws for private insurance coverage of telehealth (i.e., parity in coverage between telehealth and in-person medical services).³⁰ In Idaho, private insurers are not required to cover telemedicine services; however, at least one payer is currently implementing a small-scale pilot project to assess the feasibility of reimbursement.

Medicare provides limited reimbursement for certain telehealth services, including, but not limited to, initial consultations, follow-up inpatient consultations, kidney disease education services, diabetes self-management training services, individual psychotherapy, and pharmacologic management. A full list of telehealth services covered by Medicare can be found here: <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/telehealthsrvcfsctsht.pdf>.

Medicare patients are generally able to be reimbursed only for these services if they meet a narrow definition of residing in a rural area. Previously, rural areas were defined by the Center for Medicare and Medicaid Services (CMS) as areas not located within a metropolitan statistical area (MSA), as defined by the U.S. Census. However, in Medicare's 2014 physician fee schedule, the definition of rural was expanded to include the fringes of all MSAs, resulting in an expansion of coverage.³¹ On the other hand, as a result of changes to MSAs, Medicare beneficiaries once categorized as rural are now categorized as living within metropolitan areas and are currently at risk of losing telehealth benefits.³² For example, Butte County, Idaho, is one of 97 counties nationwide with a population at risk for losing coverage for telehealth services under Medicare.

Medicaid pays for telehealth services for the poor in most states (except for Iowa, Massachusetts, New Hampshire, New Jersey, and Rhode Island). States determine whether to cover telehealth under Medicaid; what types of services to cover; where the covered services can be delivered;

²⁹ <http://www.apapracticecentral.org/advocacy/state/telehealth-slides.pdf>

³⁰ <http://www.americantelemed.org/docs/default-source/policy/ata-map-telemedicine-parity-2014-3-7.pdf?sfvrsn=0>

³¹ <http://www.healthcarepayernews.com/content/cms-expands-medicare-telehealth-coverage>

³² <http://www.prweb.com/releases/2013/3/prweb10573921.htm>

what types of practitioners may be reimbursed; and how much to reimburse.³³ In Idaho, telehealth services are covered for participants under Medicaid and Medicare who live in a rural HPSAs or in a county outside an SMSA with a shortage of qualified providers. In Idaho, there are 332 HPSAs, and at least 1 HPSA is located within each of Idaho's 44 counties. Reimbursement is not available to anyone who receives care or corresponds with a physician via a telephone conversation, e-mail, or fax.³⁴ The State of Idaho's Medicaid reimbursement policy and procedures are available in the Telehealth Policy document here: <http://healthandwelfare.idaho.gov/Portals/0/Providers/Medicaid/TelehealthPolicy.pdf>

Reimbursement for Mental Health Services

Idaho falls in a federally designated shortage area for mental health care.³⁵ According to the Idaho Administrative Procedures Act (IDAPA), Idaho reimburses, via public health insurance programs, for telemental services deemed equal in quality to services provided in-person. Applicable services include the following:

- Psychotherapy with evaluation and management 20–30 minutes in duration
- Psychiatry diagnostic interview
- Pharmacological management
- Developmental disability (DD) therapeutic consultation
- DD crisis intervention

Optum Health administers behavioral health services to eligible Medicaid patients in Idaho.

Privacy and Security

The use of technology to provide health care may increase opportunities for patient information to be exposed.³⁶ More people may be involved in managing the technology and electronic systems associated with providing telemedicine; therefore, more people may be involved in the provision of telehealth. Also, transmitting patient data over communication lines could make it accessible to hackers if proper security measures are not taken.

The Health Insurance Portability and Accountability Act (HIPAA) applies to telemedicine in the same way that it applies to conventional medicine. Telehealth providers are expected to safeguard medical records; keep treatments confidential; and store electronic files, images, and audio/video tapes with the same precautions as paper documents. In addition, telehealth providers must ensure that patients are informed about all participants involved in a telemedicine consultation and understand that patient privacy and confidentiality will be maintained.³⁷

Under Medicaid in Idaho, according to Idaho Administrative Procedures Act policy, the equipment used to provide telehealth services must comply with HIPAA privacy requirements. If teleconferencing equipment must be operated by someone other than an employee of the

³³ <http://www.nachc.com/client/Telemedicine%20%20SPR48.pdf>

³⁴ Research provided by Stacey Carson, Vice President, Operations and Registry Services, Idaho Hospital Association

³⁵ Idaho Statewide Health Innovation Plan (December 20, 2013)

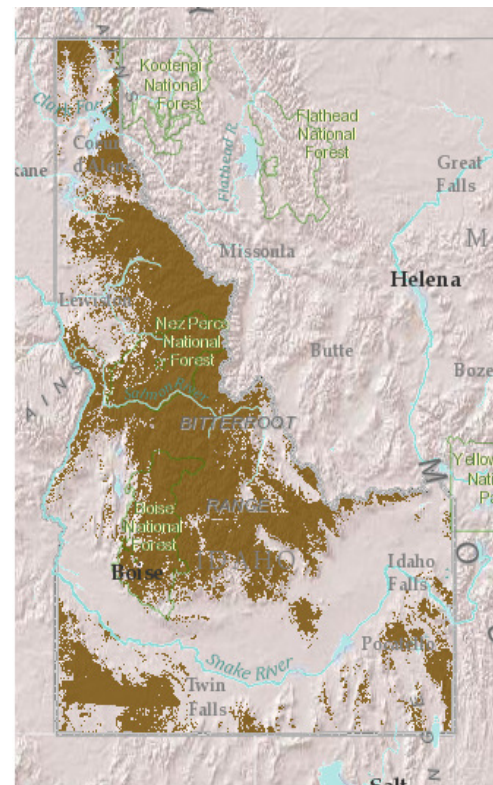
³⁶ <http://www.fiercehealthit.com/story/providers-dont-overlook-telemedicine-drawbacks/2014-01-14>

³⁷ <http://www.telehealthresourcecenter.org/toolbox-module/privacy-confidentiality-and-security>

involved agency, the operator must sign a confidentiality agreement and the form must be filed and made available to the patient upon request. If the patient indicates a desire to stop using the technology to receive health care, the service is to cease immediately, and an in-person appointment is to be scheduled.³⁸

Broadband Infrastructure

In 2009 the American Recovery and Reinvestment Act (ARRA) funded LinkIDAHO to implement projects for broadband mapping and planning, infrastructure development, public computer centers, and sustainable adoption programs. So far LinkIDAHO has developed a State broadband map that depicts where broadband is available and where there are gaps. The map shows wide swaths reportedly not covered by broadband service (see right; areas shaded in dark brown are not covered). There remains a lack of coverage in the most rural areas, precisely where telehealth is most needed to fill gaps in in-person health care.



Efforts to advance the availability of broadband service in the State include the Idaho Education Network (IEN) and the Idaho Regional Optical Network (IRON). IEN connects public schools to broadband and online educational resources. IRON is cooperation between universities in the region, the State of Idaho, the Idaho Hospital Association, and the Idaho National Laboratory to support research, education, and health care through the use of broadband technology. Other entities, such as the Nez Perce Tribe and the Idaho Commission for Libraries, have received grants to advance broadband in the State through programs such as the Broadband Technologies Opportunity Program (BTOP).

Telehealth Service Delivery

In July 2013, the Idaho Telehealth Task Force surveyed critical access hospitals (CAHs) in Idaho to better understand the extent to which each institution had the adequate connectivity and necessary equipment to provide telehealth services. Fifteen hospitals provided a response to indicate whether they had adequate connectivity to provide telehealth services; of those, 12 indicated they have adequate connectivity. Similarly, 16 hospitals provided a response to indicate whether they have the

Current Telehealth Services reported in regional stakeholder interviews:

- Telepsychiatry
- Telecardiology
- Telestroke
- Teledermatology
- Teleradiology
- Neurology
- Teleintensive care unit (ICU)
- Teleinfectious disease
- Telepharmacy
- Teleoncology
- Sleep care
- Rheumatology
- Teleemergency room consults
- Wound care
- Telehospitalists
- Acute episodic care consultation
- Neonatal resuscitation simulation program

³⁸ Research provided by Stacey Carson, Vice President, Operations and Registry Services, Idaho Hospital Association

necessary equipment; of those, 10 hospitals indicated they have necessary equipment. Appendix B provides a brief summary of the survey results from the CAHs in the seven regions.

Findings from the regional stakeholder interviews conducted in June 2014 provided further insight on the use of telehealth services across the State. All respondents indicated that some form of telehealth services was being offered at their respective institutions or regions. Most respondents reported that telehealth services had been offered in their regions for approximately 5 years, with some stating services had been offered approximately 7 years, and others reporting 2–3 years. The most commonly reported telemedicine services were tele-psychiatry and tele-cardiology, followed by telestroke and teledermatology.

Respondents also reported using telehealth technology to deliver educational and administrative services to staff and patients, including provider education, administrative meetings, peer networking, and patient education for chronic and other disease management. Interestingly, one interviewee stated that teleradiology was probably the telemedicine service used longest and most widely in his/her region. However, because the service had been seen as a routine part of care, the respondent initially had not thought of it as a telehealth service.

Respondents attributed the relatively high use of services, such as telepsychiatry, to several factors including

- a large unmet need for services, due to the shortage of health care professionals;
- the availability of reimbursement;
- the availability of telehealth providers;
- the willingness of primary care and other providers to refer patients for services because of their own reluctance to provide the service and their familiarity with telehealth providers;
- enhanced access to time sensitive;
- providers' perceptions of telehealth services as an added value to care in the event of an emergency.

Respondents were less certain of the reasons some telehealth services, such as teledermatology, had lower than anticipated utilization. Several suggested it may be due to

- the low volume of services offered because of the limited availability of telehealth providers;
- providers' perception that the service is one he/she is capable of providing without additional support;
- providers' lack of familiarity with the telehealth providers;
- lack of reimbursement for many telehealth services;
- providers' and patients' lack of knowledge about available services and how they are intended to work.

Most respondents agreed patients are, or would be, receptive to telehealth, especially when the services are explained and patients have a good understanding of what to expect during the visit. Once patients have their first positive experience with telehealth, their trust and willingness to use the services increases rapidly. Respondents reported that patients were particularly

appreciative of the reduced need for travel and the ability of their primary care physicians to remain closely involved in the coordination and management of their care.

Facilitators and Challenges to the Use of Telehealth Services

During the interviews with Task Force members and regional stakeholders, respondents were asked to discuss facilitators and challenges to the successful use of telehealth services. The most commonly reported facilitators were

- physician buy-in;
- administrative support;
- collaboration between health care providers and IT staff.

The most commonly reported challenges were

- lack of provider buy-in;
- lack of administrative support;
- limited availability of telehealth providers;
- reimbursement;
- licensing and credentialing;
- cost of equipment and technology for rural areas.

The table below provides a brief summary of each of the facilitators and challenges.

Facilitators	
Physician buy-in	<p>Primary care physicians who support telehealth services are more likely to refer their patients. Factors influencing physician support are</p> <ul style="list-style-type: none"> ■ familiarity and/or working relationships with telehealth providers; ■ belief in the quality of care provided; ■ increased accessibility to services (e.g., round-the-clock access to radiology services); ■ increased patient access to timely and convenient specialty care; ■ increased ability for providers to manage patient care in their community settings; ■ initial positive experiences with telehealth.
Administrative support	<p>Hospital and health care administrators who support telehealth services are more likely to provide resources in the short- and long-term that support the use of telehealth services such as funding, training, outreach and marketing. Factors influencing administrative support are</p> <ul style="list-style-type: none"> ■ understanding the benefits of telehealth for patients and providers; ■ understanding the benefits of telehealth for hospitals and health care institutions (e.g., cost-effectiveness of service delivery); ■ belief in the quality of care provided. <p>For administrators of small and or rural hospitals, external assistance with funding, purchase of equipment, selection of technology, training and staffing are key to enhancing their capacity and support for telehealth.</p>

Facilitators (continued)	
Collaboration between providers and IT staff	Strong collaborative relationships between providers (e.g., physicians, nurses) and information technology (IT) staff allow for a more efficient and effective use of telehealth services. IT staff can help providers become more at ease and proficient with using the equipment and technology. Good working relationships also will help IT staff better understand provider needs and ensure that the telehealth technology is equipped with the features that enhance the ability of providers and administrators to efficiently provide high-quality care.
Challenges	
Lack of physician buy-in	<p>Providers may be reluctant to support the use of telehealth services for a variety of reasons including</p> <ul style="list-style-type: none"> ▪ unwillingness to adopt new ways of providing care; ▪ lack of comfort with the equipment or technology; ▪ security- and privacy-related concerns; ▪ lack of familiarity with telehealth providers; ▪ concerns regarding the quality and continuity of care provided; ▪ lack of understanding about what constitutes a telehealth service; ▪ concerns regarding the return on investment and whether telehealth can be financially viable.
Lack of administrative support	<p>Lack of support from hospital and other health care administrators can result in</p> <ul style="list-style-type: none"> ▪ insufficient funding for activities that support the use of telehealth, such as training, marketing and promotion; ▪ inadequate planning for short-and long-term financial support of telehealth service delivery; few or no activities, such as networking events, that encourage primary care physicians to build relationships with telehealth providers; ▪ available telehealth equipment and technology not being used.
Limited availability of telehealth providers	<p>The number and availability of telehealth providers is limited due to</p> <ul style="list-style-type: none"> ▪ specialists' reluctance to provide care because of reimbursement concerns; ▪ lack of clarity about standards of care; ▪ lack of convenient access to the technology and equipment; ▪ lack of external funding to pay telehealth providers.
Reimbursement	<p>As previously stated, reimbursement poses a challenge for referring physicians, telehealth providers, hospital and health care administrators and patients. Currently, there is:</p> <ul style="list-style-type: none"> ▪ lack of clarity regarding which telehealth services are reimbursable, especially for Medicare or Medicaid patients; ▪ no provision for recouping costs for the uninsured; ▪ little to no coverage of telehealth services by private insurers.
Licensing and Credentialing	<p>State licensure can be a lengthy process which poses a barrier to telehealth providers who much be licensed in the State to deliver care. Although Idaho is one of the few states with an expedited licensure process, it appears it is not well known, understood, or used.</p> <p>Credentialing can also be burdensome for telehealth providers because it requires providers to be licensed in Idaho, recognized by insurers and to practice under the direction of the patient's physician. This is a labor- and time-intensive process that can discourage many specialists from becoming telehealth providers.</p>

Challenges (continued)	
Cost of equipment and technology	<p>The high cost of telehealth equipment and technology is particularly burdensome for small, rural hospitals and health care practices, especially those that are not part of a larger hospital system and without access to external funding to pay for or subsidize these costs.</p> <p>The use of multiple technological platforms for telehealth creates an environment where the different technologies do not “speak” to one another. As a result, primary care and telehealth providers who work in multiple locations, must become familiar with multiple technologies. This has cost implications, due to the time and resources spent learning to use the resources.</p>
Broadband coverage	<p>Although broadband coverage and access have improved considerably in the State, rural areas have limited or no access, making it difficult for hospitals in those areas to access or provide telehealth services.</p>

RECOMMENDATIONS

A synthesis of findings from the research activities conducted for the development of the Idaho Telehealth Plan identified a series of recommended action steps and strategies in three areas:

1. Engagement and Communications
2. Telehealth Service Delivery
3. Policy and Advocacy

Below is a brief summary of the recommended action steps and strategies in each area.

Engagement and Communications

- The Idaho Telehealth Task Force should work closely with the Idaho Telehealth Council to help build consensus about what constitutes telehealth and high-quality service delivery.*** A widely recognized and accepted definition of telehealth, and agreed upon standards of care, will help promote consistency in the provision of telehealth; provide a basis for accountability; and address concerns regarding the quality, privacy, security and safety of telehealth services.

 - **Action Step 1:** The Task Force should work with the Council to develop a definition of telehealth.

 - **Strategy 1.1:** Build upon the FSMB definition of telehealth services to ensure that Idaho’s definition aligns with nationally accepted standards.
 - **Strategy 1.2:** Develop a communications plan for informing all interested parties about the definition and to ensure consistent messaging for the purpose, use, and benefits of having a standard definition of telehealth for the State.
 - **Action Step 2:** The Task Force should continue to work with the Council and legislators, as appropriate, to develop standards of care for telehealth.

 - **Strategy 2.1:** Explore the feasibility of building upon standards of care identified by FSMB and the American Telemedicine Association (ATA)

- ***The Task Force should increase education and outreach efforts to health care systems to build support for telehealth services.***
 - **Action Step 1:** The Task Force should develop an education and outreach plan tailored for health care systems and administrators throughout the State of Idaho.
 - **Strategy 1.1:** It is recommended that the plan identify ways to demonstrate how telehealth services can enhance the reach and impact of existing health care service improvement initiatives in the State (e.g., TSE, PCMH).
 - **Strategy 1.2:** The plan should include strategies for developing, or encouraging the development, of tailored presentations (e.g., in-person meetings, Webinars, conferences) for Idaho hospital executives and board of trustees to promote benefits of telehealth most likely to resonate with this audience (e.g., cost-effectiveness, return on investment).
 - **Strategy 1.3:** The plan should include strategies for conducting outreach to tribal health organizations and increasing their participation in State-level telehealth planning and service-delivery efforts.
 - **Strategy 1.4:** The plan should include strategies for starting dialogues with out-of-state health care organizations that provide telehealth services in Idaho. It will be important to include these organizations, as appropriate, in current conversations to ensure their provision of telehealth services are aligned with Idaho's telehealth definition, delivery, and standards of care.
 - **Action Step 2:** It is recommended that the Task Force encourage continued partnerships between larger and smaller, often more rural hospitals as an effective strategy for increasing awareness of, and access to, telehealth services.

- ***The Task Force should increase education and outreach efforts to health care providers, particularly primary care physicians, to build their support for telehealth services.***
 - **Action Step 1:** It is recommended that the Task Force develop a plan to educate providers throughout the State about the benefits of telehealth.
 - **Strategy 1.1:** The plan should include strategies such as academic detailing for primary care providers that is specifically focused on increasing their understanding of telehealth, the availability of providers and services, ways to access services and the benefits of using telehealth services for both provider and patient.
 - **Strategy 1.2:** The plan should also include the use of respected and persuasive “champions” who are willing to conduct presentations to groups of providers and professional organizations about the availability and benefits of telehealth services.
 - **Strategy 1.3:** The plan should include strategies for creating, or encouraging the development of marketing materials specifically tailored for providers that promote the benefits of telehealth (e.g., testimonials or success stories from the provider perspective). It also will be important to identify effective and credible channels for disseminating this information to providers.
 - **Action Step 2:** It is recommended that the Task Force encourage/provide opportunities for primary care and telehealth providers to meet and build relationships. This kind of interaction will increase primary care providers' comfort

- and willingness to refer patients to telehealth providers. The Task Force can sponsor these events or encourage its members or hospitals and health care facilities to offer these opportunities.
- **Strategy 2.1:** The Task Force should discuss and identify ways to create lists of telehealth providers who work in the State. It will be important to update this list on a regular basis and have it readily accessible to providers. The list could serve as a first step in increasing primary care providers’ knowledge about who telehealth providers are and in what areas services are available.
 - **Strategy 2.2:** The Task Force should encourage events such as “Meet the Telehealth Provider” that will give primary care providers the opportunity to interact with and “get to know” telehealth providers in the State. These events can be held in person, as part of existing State conferences, or virtual.
 - **Action Step 3:** The Task Force should encourage efforts aimed at improving provider comfort with equipment and technology as a way to increase the likelihood providers will either make referrals or consider becoming telehealth providers themselves.
 - **Strategy 3.1:** The Task Force can encourage its members as well as hospitals and health care facilities to promote more deliberate collaboration between providers and IT staff. For example, IT staff can offer workshops or one-on-one tutorials specifically for providers. Another possibility may be to have a workgroup with providers and those responsible for purchasing telehealth equipment that would allow providers more input regarding features, functionality, or equipment that enhance their workflow and productivity as well as the patient experience.
- ***The Task Force should increase efforts to enhance patient awareness, support, and use of telehealth services.***
- **Action Step 1:** The Task Force should develop a plan to improve patient understanding of the availability and benefits of telehealth services.
 - **Strategy 1.1:** The plan should include marketing/education efforts tailored for patients (e.g., patients’ testimonials or success stories, articles, blogs, institution-specific marketing materials, Frequently Asked Questions [FAQ]). It will be important to identify credible channels for disseminating the information to patients, especially those in rural areas who may be infrequent users of health care.
 - **Strategy 1.2:** The plan should include strategies for encouraging providers to promote telehealth services directly to their patients (e.g., brochures of local telehealth resources that can be made available in patient waiting rooms, short DVDs promoting local telehealth services that can be played in general waiting areas).
 - **Action Step 2:** The Task Force should encourage its members and hospitals and health care facilities throughout the State to consider expanding use of telehealth for more patient education-related services (e.g., diabetes management). The Task Force can provide information about the benefits of these services, as well as potential cost and cost-effectiveness to interested hospitals and health care facilities.
 - **Action Step 3:** The Task Force should develop a plan for outreach to community-based organizations and at community-level events aimed at building awareness of the benefits of telehealth for families and communities. This would include articulation of benefits such as increased spending in local communities due to

reduced need for travel. Community events can include health fairs or other outreach events sponsored by the local community-based organizations.

- ***The Task Force should increase participation by insurers in telehealth planning, delivery, and reimbursement efforts in the State.***
 - **Action Step 1:** It is recommended that the Task Force conduct more outreach efforts to engage more insurers/payers to participate in the Taskforce and Council. Payer participation will help increase the likelihood that future efforts to expand the use of telehealth services take into consideration the needs and concerns of payers, especially as it relates to reimbursement and standards of care.
 - **Action Step 2:** It is recommended that the Task Force convene a meeting of private and public payers to discuss the future of telehealth reimbursement, each organization's respective role and plans, as well as concerns that may pose challenges to future reimbursement efforts if not adequately addressed.
 - **Action Step 3:** It is also recommended that the Task Force encourage payers who currently reimburse for telehealth services to create FAQ documents describing their organization's reimbursement policies and procedures and possibly listing contact information for an individual(s) who can answer questions that providers, patients or administrators may have. These documents will help alleviate some of the current confusion and uncertainty regarding which services are reimbursed by which organization.

Telehealth Service Delivery

- ***It is recommended that the Task Force conduct research and data collection activities that will help to improve stakeholders' understanding of patients' needs and their demand for telehealth services.***
 - **Action Step 1:** Improved understanding of how telehealth can address unmet health care needs specific to of rural populations.
 - **Strategy 1.1:** It is recommended that the Task Force conduct a county-level needs assessment to determine the leading unmet health care needs and the current availability of telehealth services to meet those needs at the county level. Hospitals, providers, and other stakeholders can use this information to advocate for the targeted expansion of services that can help fill these gaps and are most likely to be in high demand, from the patient perspective.
 - **Action Step 2:** Improve identification of services that offer the greatest benefits to patients across the State.
 - **Strategy 2.1:** It is recommended that the Task Force conduct a statewide assessment of patients' needs using a representative sample of Idaho residents. Topics for the assessment should include, but not be limited to, measuring current levels of patient awareness of the availability of telehealth services; receptivity to current and future use; patients' concerns (e.g., privacy, security, and quality of care, technology, and reimbursement); patient expectations regarding benefits; services patients want most; and services patients think they are most likely to use.
 - **Strategy 2.2:** The Task Force should conduct a survey and/or series of interviews with primary care providers to get their perspectives on how, and which,

telehealth services are most beneficial for patients as well as strategies for encouraging patient use.

- **Strategy 2.3:** It is recommended that the Task Force conduct research with current telehealth providers to identify and review best practices (e.g., tele-psychiatry) that can be transferred to facilitate the delivery of other telehealth services.
- **Action Step 3:** It is recommended that the Task Force conduct research to explore and identify reasons for low patient utilization of certain telehealth services to inform the development and implementation of strategies for increasing patient utilization.
 - **Strategy 3.1:** A survey or series of interviews with health care administrators and primary care providers is needed to better understand reasons for low (and high) utilization and how providers and health care systems can aid efforts to increase patient utilization.
 - **Strategy 3.2:** The statewide survey of patients' needs recommended as part of Strategy 2.1. can also inquire about the reasons patients may not be using currently available telehealth services.
- ***Improve understanding of cost implications of providing telehealth services.***
 - **Action Step 1:** Assess the cost and potential savings of telehealth service delivery.
 - **Strategy 1.1:** Determine the economic value of reducing travel, keeping dollars in the community, reducing ER visits and reducing hospital admissions. This can be calculated at the county and regional levels.
 - **Action Step 2:** Present findings to key stakeholders.
 - **Strategy 2.1:** Conduct webinars/ meetings with hospital and health care administrators and legislators similar to example provided in Appendix C.
 - **Strategy 2.2:** Develop user friendly materials for other audiences (e.g. business community, primary care providers).
- ***Improve the availability of telehealth providers.***
 - **Action Step 1:** Assess the adequacy of existing availability of services
 - **Strategy 1.1:** Conduct a gap analysis between available supply and demand in terms of numbers and types of providers, as well as number of available service hours and the convenience of those hours for patients.
 - **Strategy 1.2:** Survey/interview telehealth providers to understand barriers and facilitators they encounter, as well as identify what is needed to improve the supply of telehealth providers.
 - **Action Step 2:** Convene a meeting with stakeholders to brainstorm strategies for increasing the supply of telehealth providers, if the gap analysis determines more are needed. The stakeholders would include administrators, telehealth providers, as well as local residency training and residency programs.

Policy/Advocacy

- ***Facilitate the licensure process.***
 - **Action Step 1:** Work with the Idaho State Board of Medicine to increase awareness of the expedited licensure process (e.g., active marketing and promotion).

- **Action Step 2:** Work with the Idaho State Board of Medicine to assess the extent of use of expedited licensure for telehealth providers and identify common challenges and facilitators.
 - **Action Step 3:** Assess the adequacy of licensing options for nonphysician providers (e.g., agreement for nurses, 30-day provision for mental health providers) to determine what, if any, changes are needed to facilitate the process.
 - **Action Step 4:** If warranted, explore the use of other licensing options such as mutual reciprocity. This approach may be very effective for telehealth providers who are already licensed in neighboring states.
- ***Facilitate the credentialing process.***
- **Action Step 1:** Assess existing challenges and barriers for credentialing telehealth providers in different types of hospitals across the State.
 - **Action Step 2:** If credentialing is determined to be a significant barrier, explore the possibility of developing a standardized credentialing process.
 - **Action Step 3:** Engage partners with vested interest in credentialing (e.g., licensing boards for midlevel providers, Bureau of Facility Standards) to assess whether current policies or procedures need updating.
- ***Improve understanding, availability and use of reimbursement options.*** It is recommended that the Task Force provide education, materials and training about reimbursement and coverage guidelines tailored for various audiences, including primary care physicians, specialists, hospital and health care administrators, and other health care providers.
- **Action Step 1:** Improve understanding of Medicare and Medicaid policies and procedures.
 - **Strategy 1.1:** Circulate CMS policy and procedures document: <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/telehealthsrvcsfctsht.pdf>
 - **Strategy 1.2:** Circulate the Idaho Telehealth Policy document: <http://healthandwelfare.idaho.gov/Portals/0/Providers/Medicaid/TelehealthPolicy.pdf>
 - **Strategy 1.3:** Create and disseminate a user-friendly, 1-page, at-a-glance version of the Idaho Telehealth Policy document.
 - **Action Step 2:** Diversify funding streams for telehealth services.
 - **Strategy 2.1:** Build relationships with a wider array of insurers and encourage private-payer reimbursement of telehealth services.
 - **Strategy 2.2:** For those insurers who are currently conducting pilot studies regarding reimbursement, or are interested in doing so, encourage them to promote study results. The Task Force could sponsor a state-wide Webinar to share the information more broadly.
 - **Strategy 2.3:** Explore the possibility of Medicaid reimbursement for Medicare approved telehealth services.

DISSEMINATION OF THE TELEHEALTH PLAN

As part of the regional stakeholder interviews, respondents were asked to offer ideas for specific strategies to help disseminate the Telehealth Plan. Most suggested the use of targeted, tailored dissemination strategies. For example, providers, administrators, and other health care professionals may benefit from reviewing the full plan; however, a more concise, easy-to-read, highly visual, user-friendly format will be more appropriate for the business community, community-based organizations, and the general public. Respondents also suggested that a full and abbreviated version of the Telehealth Plan be posted on the Task Force Web site.

Respondents also were asked to provide suggestions for which audiences should be included in the dissemination plan. Below is the full list of suggested audiences.

- American College of Health Executives
- American Nurses Association
- Business Idaho
- Critical Access Hospitals
- Employers
- Idaho Area Health Education Center (AHEC)
- Idaho Association of County Commissioners
- Idaho Association of Family Physicians
- Idaho Department of Health and Welfare
- Idaho Hospital Association
- Idaho Legislators
- Idaho Medical Association
- Idaho Public Health Association
- Idaho Rural Health Association
- Idaho's 37 hospitals' executives and trustee board members
- Individual physician clinics
- IT staff
- Kiwanis organizations
- Medical Group Management Association
- Patients
- Pharmacists
- Qualis Health
- Residency programs
- Rotary organizations
- Rural health programs
- Social workers
- State Office of Rural Health and Primary Care
- Telehealth specialty providers
- The Hospital Cooperative
- Tribal organizations
- Universities with health care centers

NEXT STEPS

The Idaho Telehealth Task Force will partner with the Idaho Telehealth Council to review the Telehealth Plan, prioritize recommendations, action steps, and strategies for implementation and develop the necessary infrastructure (e.g., planning committees, partnerships) to implement prioritized recommendations.

Appendix A

Idaho Telehealth Task Force Executive Leadership

APPENDIX A. IDAHO TELEHEALTH TASK FORCE

Lynda Bennett, MA

Center Director

Idaho Area Health Education Center (AHEC)

Stacey Carson

Vice President, Operations & Registry Services

Idaho Hospital Association

Marc Chasin, MD

CIO

St. Luke's Health System

Robert Cuoio

Executive Director

The Hospital Cooperative

Rick Goodwin, MS

Assistant Administrator

Eastern Idaho Regional Medicaid Center

William Hazle, MD

Psychiatrist/Owner

Stargazers, LLC

Casey Meza, MHA

Executive Director

Allied Health Services

Kootenai Health

Michael Meza, MD

Telemedicine Director

Shoshone Medical Center in Kellogg

(Also working with Kootenai Health)

David Morledge, PhD, CCC-A, DABNM, FASNM

Clinical Neurophysiologist

Neurostatus, LLC

John Rusche, MD, FAAP

Minority Leader, House of Representatives

Idaho Legislature

Tiffany Whitmore Seibert

Director, Systems Planning and Telemedicine

Saint Alphonsus Health System

Appendix B

Telehealth Services Offered by Region

APPENDIX B. TELEHEALTH SERVICES OFFERED BY REGION³⁹

Region	Number of Critical Access Hospitals (CAHs) in Region	CAHs Reported Offering Telehealth	Type(s) of Telehealth Offered by CAHs	CAHs with Adequate Connectivity	CAHs with Adequate Equipment
Region 1	4	a. Benewah Community b. Bonner General c. Boundary Community d. Kootenai County e. Shoshone Medical Center	1. Psychiatry (a) 2. Radiology (c)	4	3
Region 2	4	a. Clearwater Valley b. St. Mary's c. Syringa General Hospital d. Gritman Medical Center	1. Psychiatry (adult & child) (a, b) 2. Dermatology (a, b) 3. Emergency room (ER) backup (a, b) 4. Hospitalist (a, b) 5. Psychiatry (c) 6. Pediatric psychiatry (d) 7. Cardiology (a)	3	3
Region 3	2	a. Walter Knox Memorial	N/A	0	1
Region 4	3	a. St. Luke's, Mt. Home b. St. Luke's, McCall c. Cascade Medical Center	1. Wound care clinics (a, b, c) 2. e-ICU inpatient consultations (b, c) 3. Installed ER for consultations (b, c) 4. ER (c) 5. Heart (c) 6. Stroke (c) 7. Psychiatry (c)	1	1
Region 5	5	a. St. Luke's, Jerome	1. e-ICU inpatient consultations (a) 2. Installed ER for consultations (a) 3. Wound care clinics (a)	1	0

³⁹ These data reflect responses from hospitals that completed the survey and may not be reflective of the entire region. In some cases, hospitals reported offering telehealth services but did not specify which telehealth services are offered.

APPENDIX B. TELEHEALTH SERVICES OFFERED BY REGION⁴⁰ (CONTINUED)

Region	Number of CAHs in Region	CAHs Reported Offering Telehealth	Type(s) of Telehealth Offered by CAHs	CAHs with Adequate Connectivity	CAHs with Adequate Equipment
Region 6	6	a. Bear Lake Memorial b. Oneida County c. Lost River d. Franklin County	1. Psychiatry (a, b, c, d) 2. Oncology (b)	1	1
Region 7	3	a. Eastern Idaho Regional Medical Center (EIRMC) b. Steele Memorial c. Driggs Community/ Teton Valley	1. Stroke (a) 2. Psychiatry (b, c) 3. Oncology (b)	2	2

As illustrated, the top telehealth services offered by participating hospitals were psychiatry/psychology (10), emergency care (6), and wound care (4). Hospitals were also asked to describe any key telehealth services they would like to see in their respective communities.

⁴⁰ These data reflect responses from hospitals that completed the survey and may not be reflective of the entire region. In some cases, hospitals reported offering telehealth services but did not specify which telehealth services are offered.

Appendix C

Utilizing Telemedicine to Improve Access to Medical Care in Idaho (Powerpoint presentation)

Utilizing TeleMedicine to Improve Access to Medical Care in Idaho

Presentation for the Idaho Health Care Task Force
September 10th, 2012

Tiffany Whitmore, MPA
Director, System Planning and TeleMedicine
Saint Alphonsus Health System



Casey Meza
Executive Director, Regional Services
Kootenai Health



Presentation Outline

- Introduction to TeleHealth Technology
- Idaho Overview
- Our Experiences
- The Future



Introduction

TeleHealth: *a mode of delivering health care services that utilizes information and communication technologies to enable the diagnosis, consultation, treatment, education, care management and self-management of patients at a distance from health providers.*¹



TeleMedicine: *The use of medical information exchanged from one site to another via electronic communications to improve patient's health status*¹


¹ Center for Connected Health Policy, "Advancing California's Leadership in Telehealth: Policy: A Telehealth Model Statute and Other Policy Recommendations", February 2011

Why TeleMedicine

- 35 of Idaho's 44 counties are Rural or Frontier
- Idaho has 27 Critical Access Hospitals
- 48 Medically Underserved Areas/Populations
- 158 Health Professional Shortage Areas
- Rural Idaho faces recruitment and retention challenges
- Limited access to specialty care in many areas



Our Experience: The IDA/ORE Network

 Saint Alphonbus | IDA/ORE NETWORK



IDA/ORE Network Services

Emergency Consultations	Outpatient Services	In-Patient / Other Services
<ul style="list-style-type: none"> ▪ E.D. to E.D ▪ Stroke ▪ Burns ▪ Neonatology 	<ul style="list-style-type: none"> ▪ Psychiatry ▪ Oncology ▪ Orthopedics ▪ Dermatology ▪ Rheumatology ▪ Cardiology ▪ Genetic Counseling ▪ Burn Follow-up Clinics ▪ Wound Care* ▪ Stress-echo Services* 	<ul style="list-style-type: none"> ▪ Intensivist Program ▪ Hospitalist Program ▪ Interpretive Services ▪ Televisit ▪ Education

* in development

 Saint Alphonbus Health System

Outpatient Clinics: Serving Patients at Home

Outpatient Travel Expenses	Cleanwater Valley	St. Mary's*	Grande Ronde*	SA Baker City	SA Ontario	West Valley	Walter Knox	Cascade	Syringa	SARMC
Patient Encounters	2500	956	177	4	2	1	18	221	54	92
Travel Miles Avoided	615,262	276,608	28,896	632	224	100	1,044	35,360	8,424	62,376
Expense per Mile	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5
Total Expense	\$307,631	\$138,304	\$14,448	\$316	\$112	\$50	\$522	\$17,680	\$4,212	\$31,188

Total Patient Travel Expense **Avoided**
due to Availability of TeleMedicine:

Total Miles:
1,028,962

Cost at \$0.50 per
Mile: \$514,463

*Cardiology patients at Grand Ronde must travel to Boise for care

*Child Psychiatry patients at St. Mary's and Cleanwater Valley must travel to CDA for care

*SARMC patients with severe burns were traditionally transported to University of Utah's Burn Center for care prior to TeleMedicine implementation.



Saint Alphonsus
Health System

Telepsychiatry Program

February 2009 – July 2012

Adult Psychiatry

- ❖ 201 new patients served
- ❖ 1272 total patient encounters
- ❖ 80% no current psychiatric care

Total Patient Travel
Expense **Avoided** due
to Availability of
TelePsychiatry:

Total
Miles:
715,775

Cost at
\$0.50 per
Mile:
\$357,888



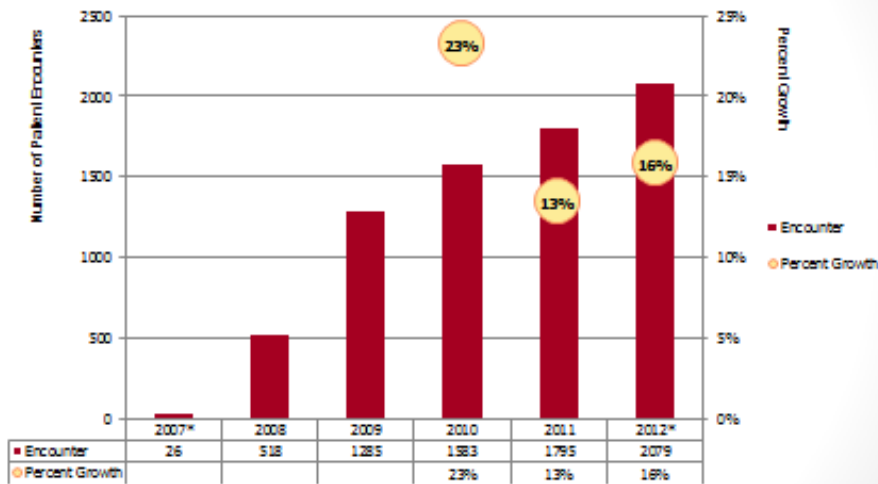
Child Psychiatry

- ❖ 90 new patients served
- ❖ 1582 total patient encounters
- ❖ 80% no current psychiatric care




Saint Alphonsus
Health System

Service Utilization: Year over Year Growth



*2007 5 months of data
*2012 Data is annualized

 Saint Alphonse Health System

Case Study: Telepsychiatry Health Care Cost Savings

Pre- Telepsychiatry Program:

- Diagnosed with schizophrenia and severe drug and alcohol abuse
- Average of 1 E.D. visit /month for 3 years = **\$46,728**
- 4 hospitalizations in 3 years

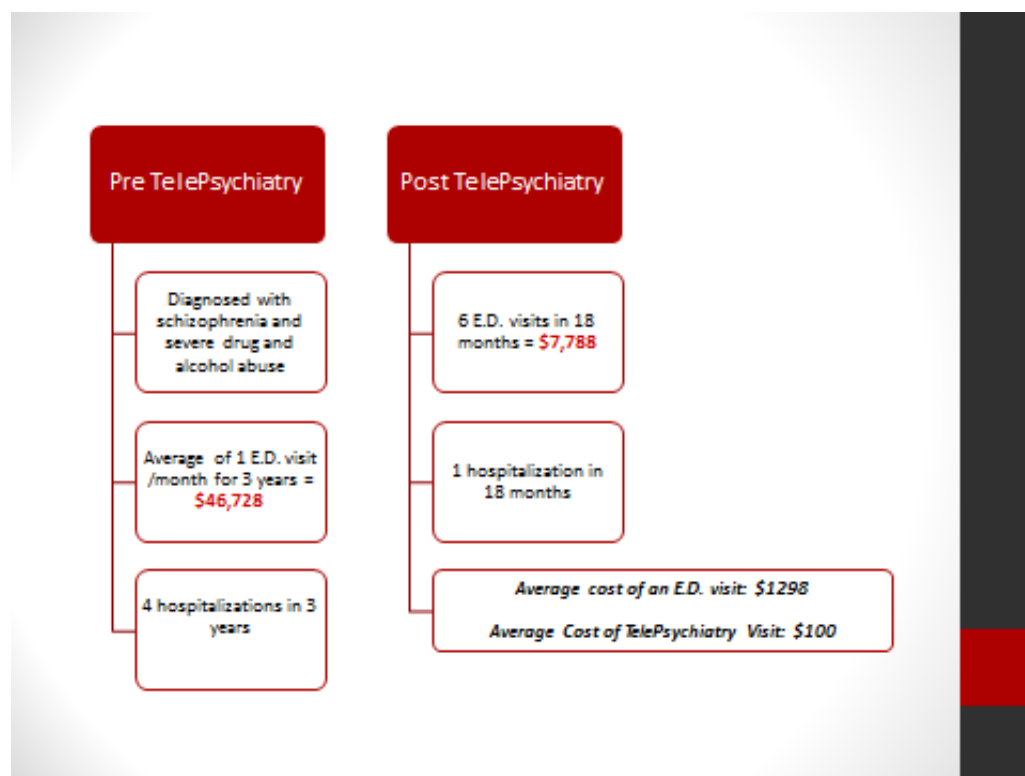
Telepsychiatry Program:

- 6 E.D. visits in 18 months = **\$7,788**
- 1 hospitalization in 18 months

Average cost of an E.D. visit = \$1298

Average Cost of telepsychiatry appointment = \$100

 Saint Alphonse Health System



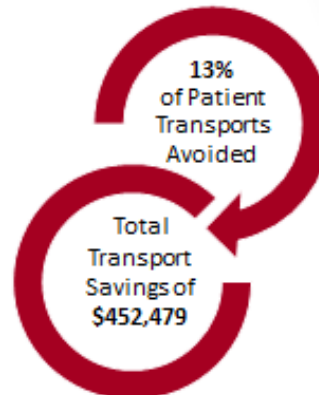
TeleHospitalist Services

- ❖ 44 inpatients retained between Nov. 2010-Nov. 2011
- ❖ Resulting in 210 days of hospitalization
- ❖ Resulting net payments to critical access hospital: \$360,000
- ❖ Significant savings to patients/payers:
 - ❖ Avoided ground/air transfer costs
 - ❖ Avoided duplication of tests
 - ❖ Avoided family travel and loss of work time
 - ❖ Improved continuity of care

Emergency Specialist Program

November 2009 – July 2012

ESP Program by Type	Patient Encounters
Stroke/Neurology	105
Burns	30
Cardiology	5
All Other Emergent	40
Total	180



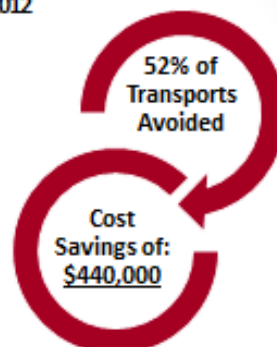
- The ESP Program coordinates specialty physicians in emergency situations using TeleMedicine technology.
- Patients can then receive care in their community hospitals when appropriate.



TeleBurn Service in Partnership with U of Utah

December 2011 – July 2012

Emergency Burn Prevented Transport	Patient Encounters
Patient Transport Avoided	11
Patient Transported to Utah	10
Total	21

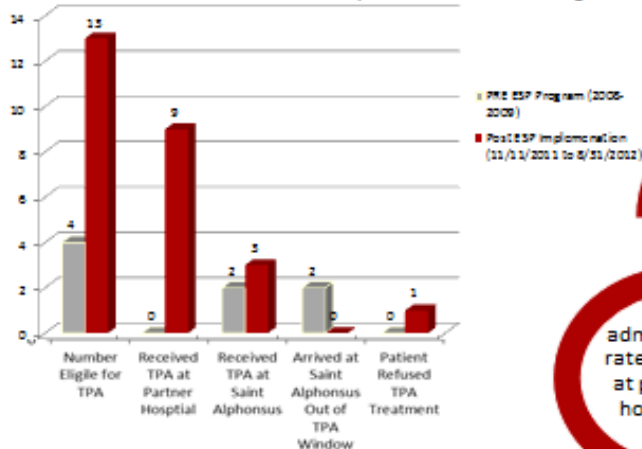


Burn Follow-Up Clinic	Patient Encounters
New Patients	39
Returning Patients	49
Unknown	4
Total	92
Travel Miles Avoided	62,376
Travel Dollars Saved	\$31,188



TeleStroke Services

TPA Administration in Rural Hospitals Pre and Post ESP Program



Provided stroke education at Partnering Hospitals & with EMS teams

TPA administration rates increased at partnering hospitals by **69%**

*TPA must be administered within a set time frame from the onset of symptoms



Case Study: Improving Stroke Care and Outcomes

Patient presents to a partnering hospital emergency room with dense right sided weakness and loss of speech.

Patient was evaluated for stroke, sent for a rapid head CT, and a Tele-Stroke consult was initiated with a Neurologist

Tele-Stroke Neurologist was able to view the CT scan immediately

Patient was deemed a candidate for IV t-pa which was initiated at 1 hour and 33 minutes from stroke symptom onset then Transferred

- Tele-Stroke Neurologist was able to re-evaluate the patient pre and post administration of t-pa
- Two hours after treatment the patient was awake, alert, and able to answer questions
- The patient was discharged with only mild weakness of his right arm
- Prior to Tele-Stroke, partnering hospital would transfer stroke patients without starting t-pa at their hospital



Future Vision

- Telehealth utilized to provide wide variety of inpatient, outpatient and emergency services throughout the state
- Rural hospitals remain financially viable as patient revenues remain in the community
- Patients receive **appropriate, timely** access to specialty services thereby reducing costs as focus switches to prevention and improved management

Thank you

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